

PRIORITY HEALTH
 priorityhealth.com
PRIORITYHSASM SUMMARY OF BENEFITS HMO 100% HOSPITAL PLAN
HOLTON PUBLIC SCHOOLS
Effective: January 1, 2010 – December 31, 2010

The following information is provided as a summary of benefits available under your **PriorityHSA** plan. This summary is not a substitute for your Certificate of Coverage and Schedule of Copayments and Deductibles. **It is not a binding contract. Limitations and exclusions apply to benefits listed below.** Coverage for services is based on Medical / Clinical necessity as determined by Priority Health's Medical Department. A complete listing of covered services, limitations and exclusions is contained in the Certificate of Coverage, Schedule of Copayments and Deductibles and any applicable riders issued to you. You may request a copy of the Certificate of Coverage from Priority Health's Customer Service Department at 616 942-1221 or 800 446-5674 or on-line at priorityhealth.com. Contact Priority Health's Customer Service Department if you have questions about your benefits or coverage.

Copayment = Member pays
% Coverage = Priority Health pays

Deductible

Individual Deductible per Contract Year	\$2,000
Family Deductible per Contract Year	\$4,000

A Deductible is the amount of covered expenses you must incur during the Contract Year before benefits will be paid. Deductible amounts you pay are included in any out-of-pocket maximums. The Deductible is applicable to all covered services except routine maternity care services received in your PCP's office, or preventive health care services that are listed in Priority Health's Preventive Healthcare Guidelines. Charges for delivery are subject to the Deductible.

Individual Contract and Family Contract Deductibles:

- If you are the only individual on your contract, you have an Individual Contract and the Individual Contract Deductible applies.
- If you have more than one individual on your contract, you have a Family Contract and only the Family Contract Deductible Applies. The Family Contract Deductible can be satisfied by any one family member or by any combination of family members.

Your deductible renews each Contract Year.

Out-of-Pocket Maximums

The Out-of-Pocket Maximum limits the total amount that you will pay toward medical Covered Services during a Contract Year.

If you have an Individual Contract, when calculating your Out-of-Pocket Maximum, we will include all Copayments and Deductibles you paid toward medical Covered Services during a Contract Year. If you have a Family Contract, we will include all Copayments and Deductibles you and your family paid collectively toward medical Covered Services during a Contract Year.

Once the applicable Out-of-Pocket Maximum is met, all further medical Covered Services for that Contract Year will be paid by Priority Health at 100% without requirement of Copayment.

Your Out-of-Pocket maximum limit renews each Contract Year.

Your Out-of-Pocket Maximum will take into account any monies paid under your prescription drug rider. See your prescription drug rider for more details.

Individual Out-of-Pocket Maximum per Contract Year	\$4,000
Family Out-of-Pocket Maximum per Contract Year	\$8,000

Basic Benefits

Physician's Services	
PCP and other Participating Physician (Includes all office and home visits not considered preventive health care services or routine maternity care services)	100% Coverage. Deductible applies.
Preventive Health Care Services (Preventive health care services are those services listed in Priority Health's preventive health care guidelines. These services must be provided by your PCP or a Participating Physician and prior approval from Priority Health if necessary.)	Services Covered in Full – No Office Copayment. Deductible does not apply.
Routine Maternity Care Services Prenatal and Postnatal Deductible applies to all charges for delivery.	No Office Visit Copayment for routine pre- and postnatal visits. Deductible applies to all other services.
Allergy Testing and Injections	100% Coverage. Deductible applies.
Outpatient Services	
Diagnostic Laboratory and X-Ray	100% Coverage. Deductible applies.
Chemotherapy	100% Coverage. Deductible applies.
Radiation Therapy	100% Coverage. Deductible applies.
Hemodialysis	100% Coverage. Deductible applies.
Rehabilitative Medicine Services	
Physical and Occupational Therapy (including spinal manipulation)	100% Coverage up to a benefit maximum of 50 visits per Contract Year. Deductible applies.
Speech Therapy	100% Coverage up to a benefit maximum of 50 visits per Contract Year. Deductible applies.
Cardiac Rehabilitation and Pulmonary Rehabilitation	100% Coverage up to a benefit maximum of 50 visits per Contract Year. Deductible applies.
Hospital Services	
Inpatient Services (semi-private room and intensive care, surgery and all related surgical services, ancillary services while inpatient) Note: Non-emergency inpatient hospital admissions, other than for normal labor and delivery, must be approved in advance by Priority Health.	100% Coverage. Deductible applies. Prior approval is required except in emergencies or for hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.
Inpatient Hospital Professional Services	100% Coverage. Deductible applies.
Outpatient Surgery at Hospital or Ambulatory Center (surgery and all related surgical services)	100% Coverage. Deductible applies. Prior approval is required for certain radiology examinations.
Outpatient Hospital Professional Services	100% Coverage. Deductible applies.
Certain Surgeries and Treatments (Physician fees only) Bariatric surgery* (limit one per lifetime) Reconstructive surgery: blepharoplasty of upper eyelids, breast reduction, panniculectomy*, rhinoplasty*, septorhinoplasty* and surgical treatment of male gynecomastia Skin Disorder Treatments: Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment. Varicose veins treatments Sleep apnea treatment procedures*	Physician fees are Covered at 50%, after deductible, of the first \$2,000.00 for each certain surgery or treatment, 100% thereafter. If applicable, any hospital services Copayment also applies. *Prior approval required for bariatric surgery, panniculectomy, rhinoplasty, septorhinoplasty and sleep apnea treatment procedures.
Emergency Medical Care (in or out of the service area)	
Hospital Emergency Room	100% Coverage. Deductible applies.
Urgent Care Center	100% Coverage. Deductible applies.
Physician's Office	100% Coverage. Deductible applies.
Ambulance (land or air)	100% Coverage. Deductible applies.

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Family Planning/Infertility Services	
Vasectomy	100% Coverage for physician services; coverage limited only to when performed in physician's office or when in connection with other Covered inpatient or outpatient surgery. Deductible applies. 100% Coverage for outpatient and inpatient facility charges; coverage limited only to when performed in connection with other Covered inpatient or outpatient surgery. Deductible applies.
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Professional Services	100% Coverage. Deductible applies.
Outpatient Facility Charges	100% Coverage. Deductible applies.
Inpatient Facility Charges	100% Coverage limited only to when performed in connection with delivery or other Covered inpatient surgery. Deductible applies.
Infertility services for diagnostic, counseling and planning services for treatment of the underlying cause of infertility	50% Coverage. Deductible applies. Prescription drugs for infertility treatment Covered only with prescription drug rider.
Mental Health/Substance Abuse Services	
Note: All Mental Health and Substance Abuse services must be approved in advance by our Behavioral Health Department 616 464-8500 or 800 673-8043. Treatment may be covered as deemed clinically necessary by our Behavioral Health Department.	
Inpatient Mental Health & Substance Abuse Services (including rehabilitation and partial hospitalization)	100% Coverage. Deductible applies. Prior approval required
Outpatient Mental Health & Substance Abuse Services (including medication management visits)	100% Coverage. Deductible applies. Prior approval required
Other Services	
Durable Medical Equipment	100% Coverage. Deductible applies.
Prosthetics & Orthotics	100% Coverage. Deductible applies.
Skilled Nursing, Subacute, Inpatient Rehabilitation and Hospice Facility	100% Coverage up to the benefit maximum of 90 days per Contract Year. Deductible applies. Prior approval required.
Home Health Care (Including Hospice Services)	100% Coverage. Deductible applies.
Temporomandibular Joint Syndrome (TMJS)	50% Coverage. Deductible applies.
Orthognathic Surgery	50% Coverage. Deductible applies.

Additional Benefits

Pharmacy Services	
Prescription Drugs	Covered with a \$10 Generic/\$40 Brand Name Copayment per prescription. Includes prescription contraceptive drugs and implantable contraceptive drugs. Contraceptive devices administered or supplied in the physician's office are covered at 50%. Does not cover condoms, foams, jellies, ointments and other drugs or devices available over the counter. Infertility drugs covered with a 50% Copayment. (Limitations apply) Deductible applies.
Note: Prescription drug coverage is based on the usage of a medication formulary.	
Prescription Mail Order	Prescription drugs filled for up to 90 days with a \$20 Generic / \$80 Brand Copayment per prescription. Includes prescription contraceptive drugs and implantable contraceptive drugs. (Limitations apply). Deductible applies
Hearing Care	One hearing exam, one audiometric exam and one basic hearing aid per ear every 36 months. Hearing and audiometric exams covered in full. Hearing aid covered in full to a maximum of \$500 per hearing aid.

Eligibility Information

Dependent (Continuation)	Covered until dependent reaches age 25, regardless of student status.
Sponsored Dependent	Coverage for eligible dependents (as defined by group) who are legally related to subscriber and reside with subscriber, and who are not eligible for Medicare or Medicaid.
Early Retiree Coverage	Not Available
65+ Retiree Coverage	Not Available